SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 Individual	SERFF Tr Num: AENX-126580713	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 45404
Sub-TOI: H21.000 Health - Other	Co Tr Num: AH AR0303101F01	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI AetnaSPI	Disposition Date: 04/12/2010
	Date Submitted: 04/12/2010	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: 2010 Individual	Status of Filing in Domicile:
Project Number: AH AR0303101F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/12/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/12/2010
Deemer Date:	Created By: SPI AetnaSPI
Submitted By: SPI AetnaSPI	Corresponding Filing Tracking Number:

Filing Description:

The form listed above is being submitted for your Department's review and approval. This form is the non-internet version of the AARP Application form [GR-68388-5 (Web 1-10) submitted to your Department on April 12, 2010 [under SERFF Tracking Number AENX-126580241]. The subject form is new and does not replace any form previously approved by your Department.

The enclosed AARP Application form GR-68388-5 (1-10) will be used with our AARP Booklet-Certificate Form GR-9N COMP and GR-9N LME which were approved by your Department on September 26, 2007 under SERFF tracking number AETN - 125275941.

SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Company and Contact

Filing Contact Information

Dina Bagdigian, Compliance Specialist
151 Farmington Avenue
Mail Stop RW61
Hartford, CT 06156

BagdigianEA1@Aetna.com
860-273-8187 [Phone]
860-952-2069 [FAX]

Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-7546 ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name: Aetna
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	$50.00	04/12/2010	35564644

SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/12/2010	04/12/2010

SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Disposition

Disposition Date: 04/12/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter, Transmittal Form	Approved-Closed	Yes
Form	AARP Paper Application	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/12/2010	GR-68388-5 (1-10)	Application/ Enrollment Form	AARP Paper Application	Initial		0.000	GR-68388-5 (1-10).PDF

AARP®

Essential Premier Health Insurance - AR

insured by Aetna®

Applicant's Social Security Number

Enrollment Form ID Number

Instructions and Important Information:

- **Please PRINT clearly**. Enrollment form must be completed by the Applicant in blue or black ink. **No pencil or correction fluid. (A photocopy of this enrollment form will not be accepted.)**
- The Applicant must complete the enrollment form. You are responsible to ensure that the information on the enrollment form is correct, complete, and truthful.
- Any misrepresentation of information on the enrollment form may result in cancellation of coverage.
- The enrollment form must be received by Aetna's underwriting department within 30 days from the signature date.
- You are ineligible for coverage, if as non-citizen of the United States, you have not resided in the U.S. for six (6) consecutive months.
- **This enrollment form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.**
- Your insurance will become effective only if this enrollment form is approved as applied for, and the appropriated premium is enclosed.
- Coverage is not guaranteed until approved in writing by Aetna. DO NOT cancel your current insurance coverage until you have been notified of your approval by Aetna and your Aetna coverage is in effect.
- **Signature and date is required on Page 10, Section R for all applicants including spouse/domestic partner (DP) and children age 18 and over.**
- Underwritten by Aetna Life Insurance Company through an AARP group trust arrangement in the District of Columbia. The AARP Health Insurance Plan is a trust that holds the master group insurance policy issued by Aetna. Participants are issued certificates of insurance by Aetna under the master group insurance policy.
- Once you submit this enrollment form, you may be contacted at any time via telephone by an Aetna representative to complete your enrollment form and the underwriting process. Please do not answer any questions if you are not satisfied with the identity of the caller. Please call **[1-866-898-3267]** if you have any questions or concerns.

For Assistance with this Enrollment Form, please call: 1-866-660-4081

[Send completed enrollment form to:

Aetna AARP Plans
PO Box 14015
Lexington, KY 40512-4015**]**

Aetna Use Only

Prior Coverage: ☐ **Y** ☐ **N** ☐ **U**
Effective Date:

A. Applicant Information

Name	**AARP MEMBERSHIP ID NUMBER:**

Mailing Address (All Aetna correspondence will be sent to this address) – Include Apartment Number, if applicable. Number, Street _____ County _____ City, State, ZIP Code _____	Billing Address (If you prefer your bill to be mailed to a different address than listed above) - Include Apartment Number, if applicable. Number, Street _____ City, State, ZIP Code _____

Telephone Numbers
Home ( ) Work ( ) Cell ( )

Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Occupation	E-mail Address	Do you read and write English? ☐ Yes ☐ No

[Choose desired benefit plan type: **Premier:** ☐ $1500 Deductible ☐ $2500 Deductible ☐ $5000 Deductible *These plans may have previously been referred to as Limited plans. **High Deductible:** ☐ $3000 Deductible ☐ $5000 Deductible**]**	**Preventive and Hospital*:** ☐ $1250 Deductible ☐ $3000 Deductible	**Reason for enrollment form:** ☐ New Enrollment ☐ Add Spouse/Domestic Partner/ Dependent Child to an Existing Plan ☐ Add Dependent Child Only to an Existing Plan ☐ Change Existing Benefit Plan ☐ Request for Rate Review

Please check if applicable:
☐ I am eligible for health benefits offered by my employer ☐ I am a sole proprietor or I am self-employed

Is any person listed on this enrollment form a "non-citizen resident" of the United States? ☐ Yes ☐ No

If "Yes," has that person(s) resided within the United States for the past six (6) consecutive months? ☐ Yes ☐ No

If "No," provide the name(s) and explanation.

***In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.**

Applicant's Social Security Number

Enrollment Form ID Number

B. Individuals to be Covered ***(Unmarried dependent children are covered up to age 19; and between the ages of 19 to 25 with proof of full-time student status.)***

☐ ***Check here if more space is needed to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this enrollment form.***

Family Code	Name Last	First	M.I.	Social Security Number	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Height (ft / in)	Weight (lbs)	Full-time Student Age 19 or older
APP	Applicant									**N/A**
SP/DP	Spouse/Domestic Partner									**N/A**
01	Dependent									☐ Yes ☐ No
02	Dependent									☐ Yes ☐ No
03	Dependent									☐ Yes ☐ No

C. Other Insurance - Please attach copy of Continuation of Coverage Certificate and/or letter for each person, if applicable.

Do you currently have any health care coverage? ☐ Yes ☐ No | Are your spouse/domestic partner/children also covered? ☐ Yes ☐ No

Provide name of current (or most recent) health care carrier and coverage termination date (if applicable).
Name: _____ Term Date: _____

Are any family members listed above currently enrolled in an Aetna Advantage Plan or AARP Essential Premier Plan? ☐ Yes ☐ No
If "Yes," provide names and relationship: _____ ID No.: _____

Has any person listed on this enrollment form ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance? ☐ Yes ☐ No If "Yes," provide the following information.
Name: _____ Explanation: _____

Has any person listed on this enrollment form had their health insurance rescinded? ☐ Yes ☐ No If "Yes," provide the following information.
Name: _____ Explanation: _____

Has any person ever filed a claim and/or received benefits from disability insurance or Workers' Compensation? ☐ Yes ☐ No
If "Yes," provide the following information.
Name: _____ Date: _____ Explanation: _____

If you are currently covered by another carrier do you agree to discontinue the similar coverage prior to or on the effective date of the AARP Essential Premier Plan?
☐ Yes ☐ No If "No," explain: _____

Are any persons listed above eligible for Medicare? ☐ Yes ☐ No Note: If you are currently on Medicare, you are ineligible for an AARP Essential Premier Plan.
Name: _____ Name: _____

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Include information for all persons applying for coverage.)*

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this enrollment form.**

In the past five (5) years, has any person listed on this enrollment form consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

D1.	**Eyes, Ears, Nose and Throat Conditions/Disorders:** *Eyes/sight:* • Glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections *Ears/Hearing:* • Loss of hearing, deafness, infections, eustachian tube dysfunction *Nose/breathing:* • Deviated septum, polyps, adenoiditis, sinusitis *Throat/Swallowing:* • Tonsillitis, strep throat, excessive snoring or sleep apnea	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D2.	**Skin Conditions/Disorders:** Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Continued*)

D3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, **asthma**, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D5.	**Digestive Conditions/Disorders:** Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding Colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diarrhea, intestinal problems, colon polyps, rectal bleeding or hemorrhoids Diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D10.	**Male Reproductive Conditions/Disorders:** Fertility/infertility treatment, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility treatment, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If "Yes," provide name(s) and reason: Name(s): _____ Reason(s): _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	c) **Has any female had an abnormal PAP smear? If "Yes," provide details in F1**. Date of last normal PAP smear. Name: _____ Date: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	d) Is any female applying for coverage pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide name: Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Continued*)

D12.	**Nervous, Mental and Behavioral:** Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D14.	**Birth Defects/Congenital Abnormalities:** Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, birthmarks club foot, webbed fingers/toes, skull/facial or other physical deformities	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D15.	**Other Conditions:** Has any person applying for coverage consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this enrollment form?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

E. Health Related Questions *(Include information for all persons enrolling for coverage.)*

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this enrollment form.**	
E1.	Is any ***male*** expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is enrolling for coverage on this enrollment form? If "Yes," provide name below. Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E2.	Has any person applying been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide name(s) below. Name: _____ Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E3.	Has any person applying ever used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Name: Type of Drug/Substance: Date Discontinued: _____ _____ _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E4.	Has any person applying consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Name: Type: Amount: _____ _____ _____ per ☐ Day ☐ Week ☐ Month _____ _____ _____ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E5.	Has any person applying been convicted of a DUI (drunk driving violation)? If "Yes," provide name(s), state(s) and date(s). Name: State: Date: _____ _____ _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E6.	Has any person applying been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E7.	Has any person applying received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered **abnormal**?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E8.	Has any person applying been advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E9.	Has any person applying been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

E. Health Related Questions (*Continued)*

E10.	Has any person seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E11.	Has any person applying smoked or used tobacco products, such as snuff and/or chewing tobacco, in the last 2 years? If "Yes," provide name(s) below. Name: Date Stopped: _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E12.	Has any person applying taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E13.	Has any person applying ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this enrollment form?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E14.	Is any person applying a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E15.	Is any person applying currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

F. Detailed Health Information

☐ ***Check here if more space is needed. Use a separate sheet of paper and staple to the back of this enrollment form.***

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections D and E.

Family Code*	Ques. No.	Dates From	Dates To	Explain Nature of Illness/Condition	Describe Treatment Recommended and/or Received	Do you consider yourself "Fully Recovered"
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

2. List all prescription medications and or doctor's samples taken by you and/or your named spouse/domestic partner/dependents within the last 2 years.

Family Code*	Ques. No.	Date Prescribed (Mo./Day/Yr.)	Date Discontinue (Mo./Day/Yr.)	Name of Medication	Dosage and Frequency	Reason/Condition

***See Family Code explanation on Page 2, Section B.**

continued

Applicant's Social Security Number

Enrollment Form ID Number

F. Detailed Health Information (*Continued*)

3. For details and medications indicated above, please list ALL doctors, medical attendants, or practitioners you and/or any named spouse/ domestic partner/dependents consulted. If none, please state "None."

Family Code*	Question Number and/or Reason	Name, Address, and Phone Number of Attending Physician

4. List the last doctor visit for all family members, including routine check-ups.

Family Code*	No Visit	Purpose of Visit	Date of Visit	Results of Visit	Name, Address, and Phone Number of Physician
APP					
SP/DP					
01					
02					
03					

***See Family Code explanation on Page 2, Section B.**

G. Race/Ethnicity – Optional

Family Code*	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating, or claim payment.)					
APP	☐ White – 01	☐ African American or Black – 02	**02**	☐ White – 01	☐ African American or Black – 02	
	☐ Hispanic or Latin – 03	☐ Asian – 04		☐ Hispanic or Latin – 03	☐ Asian – 04	
	☐ Other – 05 _____			☐ Other – 05 _____		
SP/DP	☐ White – 01	☐ African American or Black – 02	**03**	☐ White – 01	☐ African American or Black – 02	
	☐ Hispanic or Latin – 03	☐ Asian – 04		☐ Hispanic or Latin – 03	☐ Asian – 04	
	☐ Other – 05 _____			☐ Other – 05 _____		
01	☐ White – 01	☐ African American or Black – 02				
	☐ Hispanic or Latin – 03	☐ Asian – 04				
	☐ Other – 05 _____					

H. Effective Date (Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested.)

If Aetna approves my enrollment form, I am requesting an effective date of the ☐ 1st of _____ (month). You will be given the requested effective date if Aetna approves the enrollment form within 30 days. This date must be no later than 90 days after the signature date (**Page 10, Section R**) of this enrollment form. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. No requested effective date will be honored prior to or on the signature date.

I. Statement of Enrollment Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on his or her own health risk. If one or more family members are not approved, Aetna will cover the approved family members unless otherwise indicated below.

☐ I, the applicant, instruct Aetna not to cover any eligible family members unless all family members are approved for coverage.

☐ I prefer to receive written communication regarding my enrollment form via email.

The information I obtained to assist in applying for this coverage was provided to me: ☐ In person ☐ Over the phone ☐ On the web

Applicant's Social Security Number

Enrollment Form ID Number

J. PAYMENT OPTIONS - Please select the method of payment for your initial enrollment form and subsequent premium payments.

Initial Payment

☐ Easy Pay (complete the EFT information below)
☐ Credit Card (complete the credit card information below)

Recurring or Subsequent Payment

☐ Easy Pay (complete the EFT information below)
☐ Bill me monthly

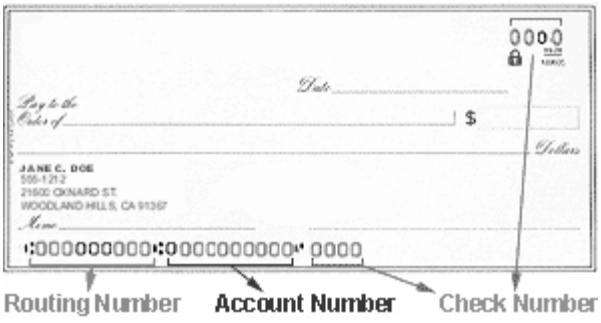
Easy Pay (Electronic Fund Transfer – EFT; An electronic payment of funds from your bank)

Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____



Terms of Agreement: My account(s) at the institution named has sufficient funds to pay all debits and charge credits. Aetna shall initiate electronic debit, charge, or credit entries to pay premiums/charges for authorized policies, and the entries are my transaction receipt. There is no payment to Aetna until Aetna receives full and final credit for the payment. I understand that corrections to the entries may involve an account adjustment, and that **my direct electronic payment of Aetna's premium will be debited/charged on or after the premium due date.** I understand that by electing the EFT box above and with my enrollment form signature on **Page 10, Section R**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account upon approval of your enrollment form. Please be advised that such rate adjustment may result in an increase of 0% to 100% of the standard premium.

NOTE: Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Page 10, Section R**) even if not applying.

Credit Card Payment Option

Credit Card Type ☐ Visa ☐ MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. You must elect EFT or monthly billing for your next premium payment.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. Please be advised that such rate adjustment may result in an increase of **0% to 100% of the standard premium**.

K. Statement of Accountability - To be completed if the applicant cannot complete the enrollment form.

I _____ in representation of the applicant, acting as _____ (describe your relationship) have personally read this form to the applicant and completed the enrollment form because:

☐ Applicant does not have sufficient command of the English language to complete this enrollment form
☐ Applicant is legally incapacitated and unable to complete this enrollment form

I have read and explained in detail the contents of this enrollment form.

_____

If translated, I also fully explained the "Conditions and Agreement" under **Section Q**. to the applicant.

Signature of Representative ***(Required):*** _____ Today's Date ***(Required)***: _____

Print Name: _____

Street Address: _____

City, Zip Code, State: _____ Phone Number: _____

Applicant's Social Security Number

Enrollment Form ID Number

L Insurance Producer Attestation – To be completed by Insurance Producer or Broker/General Agent.

	General Agent	Insurance Broker
1. Did you see the proposed applicant (and spouse/domestic partner, if applying) at the time this enrollment form was executed? If "No," please explain.	☐ Yes ☐ No	☐ Yes ☐ No
2. To the best of your knowledge, is the information on this enrollment form complete and accurate? If "No," please explain.	☐ Yes ☐ No	☐ Yes ☐ No
3. You have explained in easy to understand English (or via translation where applicable) the risk to the applicant of providing inaccurate information on this enrollment form, and that the applicant fully understands your explanation.	☐ Yes ☐ No	☐ Yes ☐ No

Signature of Insurance Producer (Required if applicable)		**Signature of General Agent** (Required if applicable)	
Date	E-mail Address	Date	E-mail Address
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name)		Name of General Agent (print name)	
TIN of Producer or Agency to be assigned as Broker of Record		Agent TIN Number	
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Telephone Number ( )	Fax Number ( )	Telephone Number ( )	Fax Number ( )

M. Aetna-appointed Sales Representative

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)

[N. Contact Information

Please return this enrollment form to the agent or submit to the address listed below.

Aetna AARP Plans
PO Box 14015
Lexington, KY 40512-4015]

Fax #: 877-838-6206

O. Important Reminders – Please Review Prior To Signing

To avoid delays in underwriting, please review this enrollment form for missing or incomplete information such as:

- Height and Weight
- Date of Birth
- Physician's address and phone number
- Complete mailing address information, including: city, state and ZIP code
- Complete answers to all Health History questions
- First and Recurring payment options
- Social Security Number for each applicant on **Page 2, Section B**
- **Social Security Number for the primary applicant at the top of each page**

If additional information or explanation is necessary, attach extra sheets to the back of this enrollment form. **All attachments must include primary Applicants Last Name, First Name and be signed and dated.**

Applicant's Social Security Number

Enrollment Form ID Number

P. Joinder Agreement

I, _____, have chosen one of the AARP individually underwritten health group products. I understand that such products are underwritten by Aetna Life Insurance Company (the "Insurer") through the AARP Health Insurance Plan (the "Trust"). To receive coverage under the products I have chosen I understand that I will have to join and be a member in good standing of AARP or a spouse/domestic partner and/or dependent of an AARP member and participate in the Trust, as defined in the coverage documents. I also fully understand and agree that no coverage shall become or remain effective as to an applicant (myself, my spouse/domestic partner or dependents) if applicant (myself, spouse/domestic partner or dependents) fails to meet minimum underwriting or eligibility requirements of AARP and/or Aetna. Each applicant who meets the requirements will be offered coverage. I agree to the enrollment criteria as I myself indicated in the Statement of Enrollment Conditions section of this form.

I, the undersigned, also: 1) agree to be bound by the terms of the policy (including all of its attached documentation) issued to the Trust (including any amendments); 2) request coverage for myself and/or for my spouse/domestic partner and/or dependents under the policy or policies issued to the Trust (subject to the applicable underwriting requirements of the Insurer) and that such coverage become effective as of the date of my or my spouse/domestic partner and/or dependents approval for participation under the Trust; 3) agree that the covered benefits provided shall be in accordance and shall be subject to the terms of the policy or policies issued to the Trust; 4) agree to make the required contributions and payment of premiums to the Trust; and 5) also agree that in the case of default, fraud or no payment I will be liable to AARP and the Insurer for such fraud, or unpaid contributions for the coverage period, and AARP and the Insurer may terminate coverage.

Applicant/Parent or Legal Guardian Signature	Today's Date
Applicant's Spouse (If enrolling for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date

Q. Conditions and Agreement - Please Read Before Signing Below

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this enrollment form and applying for this coverage, I on behalf of myself and the spouse/domestic partner and/or dependents listed on this enrollment form ("Applicant(s)"), agree to or with the following:

1. Aetna may decline this enrollment form. No coverage comes into effect until Aetna approves this enrollment form.
2. Coverage and benefits, once they come into effect, are contingent on timely and accurate payment of premiums and any other contribution provided in the plan documents. If payment of premiums or any other contribution is not paid in time and accurately, your coverage will be terminated immediately. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans.
3. I authorize Aetna to request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this enrollment form and to make a decision on the approval or disapproval of this enrollment form. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to Applicant(s) that are applying for coverage under this enrollment form to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this enrollment form.
4. I understand that Aetna will rely on such information to: 1) underwrite this enrollment form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the persons applying for coverage; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations.

   I authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
5. I understand that I am entitled to receive a copy of this enrollment form upon request, and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.
7. Agents may be compensated based on an individual's enrollment in this plan. Information on insurance agent/broker compensation is available from your agent or at Aetna.com.

Applicant's Social Security Number

Enrollment Form ID Number

R. Signature(s) Required - All persons applying for coverage age 18 and over must sign and date below.
If person applying is a minor, the enrollment form must be signed by a parent or legal guardian.

I understand that if my signature/date do not appear and/or are not current and/or my answers are incomplete this enrollment form will be declined.

I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant(s) listed in this enrollment form after the signature date on this enrollment form and before the effective date of the coverage, if approved.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

By signing below, Applicant(s) agree to the statements listed above on this enrollment form and represent that all information supplied on this form is true and complete to the best of their knowledge. Applicant(s) have read, understand, and agree to the conditions of enrollment on this enrollment form. Applicant(s) understand that the information supplied in this form will be decisive for the approval of this enrollment form and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which Applicant(s) are applying.

Applicant/Parent or Legal Guardian Signature	Today's Date
Applicant's Spouse/Domestic Partner (If enrolling for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date

[AARP®
Essential Premier Health Insurance
insured by Aetna®
]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE - AR

Aetna – AARP Plans
PO Box 14015
Lexington, KY 40512-4015

According to (your Application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Aetna Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature	Date

SERFF Tracking Number:	*AENX-126580713*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*45404*
Company Tracking Number:	*AH AR0303101F01*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Individual*		
Project Name/Number:	*2010 Individual/AH AR0303101F01*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	04/12/2010
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	04/12/2010
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	04/12/2010
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	04/12/2010
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter, Transmittal Form	Approved-Closed	04/12/2010
Comments:			
Attachments:			

Cover Letter.PDF
Transmittal Form.PDF

John W. Ciesielski
Product & Regulatory Approvals
Law and Regulatory Affairs
151 Farmington Ave.,RW61
Hartford, CT. 06156-7330
Phone Number: (845) 279-1282
Fax Number: (860) 952-2065
E-mail: Ciesielskijw@aetna.com

April 12, 2010

Insurance Commissioner Julie Benafield Bowman
Compliance – Life and Health
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: **Aetna Life Insurance Company - NAIC No. 00160054**
Group Accident and Health Insurance
AARP Enrollment Form GR-68388-5 (1-10)

Dear Ms. Benafield:

The form listed above is being submitted for your Department's review and approval. This form is the non-internet version of the AARP Application form [GR-68388-5 (Web 1-10) submitted to your Department on April 12, 2010 [under SERFF Tracking Number AENX-126580241]. The subject form is new and does not replace any form previously approved by your Department.

The enclosed AARP Application form GR-68388-5 (1-10) will be used with our AARP Booklet-Certificate Form GR-9N COMP and GR-9N LME which were approved by your Department on September 26, 2007 under SERFF tracking number AETN-125275941.

The required Transmittal Form accompanies this letter.

An Aetna Life Insurance Company electronic fund transfer in the amount of $50.00 is enclosed, in payment of your Department's filing fee.

We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this submission, please do not hesitate to contact me at the address above or at the following telephone number: (845) 279-1282

Sincerely,

John W. Ciesielski

John W. Ciesielski
Consultant

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3. **Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT		001	60054	06-6033492	

4. **Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
Dina Bagdigian 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156	860-273-8187	860-952-2069	BagdigianEA1@Aetna.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	AH AR0303101F01
7.	☐ **New Submission** ☐ **Resubmission**	Previous file # _____
8.	**Market**	☒ Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H21 Health - Other
10.	**Product Coding Matrix Filing Code**	H21.000 Health - Other
11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____

12.	**Filing Submission Date**	April 12, 2010
13.	**Filing Fee (If required)**	Amount $50.00 (EFT) EFT Date April 12, 2010 Retaliatory ☐ Yes ☒ No Check Number
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	

The form listed above is being submitted for your Department's review and approval. This form is the non-internet version of the AARP Application form [GR-68388-5 (Web 1-10) submitted to your Department on April 12, 2010 [under SERFF Tracking Number AENX-126580241]. The subject form is new and does not replace any form previously approved by your Department.

The enclosed AARP Application form GR-68388-5 (1-10) will be used with our AARP Booklet-Certificate Form GR-9N COMP and GR-9N LME which were approved by your Department on September 26, 2007 under SERFF tracking number AETN - 125275941.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Dina Bagdigian Title Compliance Specialist

Signature _____ Date April 12, 2010